

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A funeral certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Items 11, 13, 14, Film G232 8-18-58 et										
9008 Item 22, Film 232 8-21-58 et										
Reg. Dist. No. 09007										
1. PLACE OF DEATH a. COUNTY Charles MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata Md.					c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Edwin First Middle Last Brazil Brown					4. DATE OF DEATH August 7/ 1958 Month Day Year					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 4/58		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Newburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Louis Wills					14. MOTHER'S MAIDEN NAME Grace Rebecca Brown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 DUE TO atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Post maturity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 8-4 1958 to 8-7 1958, that I last saw the deceased alive on 8-7 1958, and that death occurred at 7:25 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lorenzo Lopez M.D. PHYSICIAN'S NAME (Type) LORENZO LOPEZ PHYSICIAN'S MEMORIAL HOSP. LA PLATA MD 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 8-7-58 22c. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery 22d. LOCATION (City, town, or county) (State) Shiloh, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR DATE AUG 8 '58 24b. REGISTRAR'S SIGNATURE										

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 Film 233 9-11-58 et

09008

9009

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Faulkner</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Faulkner</u>		STREET ADDRESS (If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>William</u> (Middle) <u>B.</u> (Last) <u>BUTLER Sr.</u>				(Month) <u>Aug</u> (Day) <u>29</u> (Year) <u>1958</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>NEGRO</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>Sept 17 1868</u>	<b>9. AGE last birthday</b> <u>90</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>		<b>IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Orsterius Butler</u>				<b>14. MOTHER'S MARDEN NAME</b> <u>Elizabeth ANN Swann</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>William B. Butler Jr, Bel Alton, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>Cerebral occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Semile arterio-sclerotic disease</u>				<u>10 years.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>June 29 Aug 1958</u> , <b>to</b> <u>29 Aug 1958</u> , <b>that I last saw the deceased alive on</b> <u>29 Aug 1958</u> , <b>and that death occurred at</b> <u>11:00 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Howard M.D.</u>				<b>DATE SIGNED</b> <u>29 Aug 58.</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>24. REC'D BY REGISTRAR</b> <u>Arthur L. Knaus</u>			
<b>DATE</b> <u>SEP 4 '58</u>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Hunt Funeral Home, Waltham, Md.</u>			

CERTIFICATE OF DEATH

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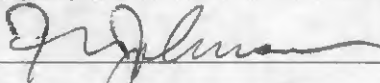

NAME OF DECEASED Charles  
AGE 72 SEX M  
DATE OF BIRTH 1881  
PLACE OF BIRTH Massachusetts

DATE OF DEATH 1952  
PLACE OF DEATH Home  
CAUSE OF DEATH Heart Disease  
MANNER OF DEATH Natural

Signature of Physician [Signature]  
Signature of Registrar [Signature]  
Signature of Family [Signature]

DATE OF REGISTRATION 1952  
PLACE OF REGISTRATION Massachusetts  
REGISTRAR'S SIGNATURE [Signature]

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13641
Item 18 Film 236 12-22-58 ams										
11931										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <b>Charles</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>					c. LENGTH OF STAY IN 1b <b>2 days</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physician's Memorial</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cannady</b>					4. DATE OF DEATH Month Day Year <b>August 29 19 58</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/26/58</b>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <b>3</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Melvin Cannady</b>					14. MOTHER'S MAIDEN NAME <b>Agnes Hotor</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>8-26</b> , 19 <b>58</b> , to <b>8/29</b> , 19 <b>58</b> that I last saw the deceased alive on <b>8/28/58</b> , 19 <b>58</b> , and that death occurred at <b>4 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED										
ACTUAL SIGNATURE  M.D.					PHYSICIAN'S NAME (Type) <b>F. M. Johnson, M.D.</b> <b>La Plata, Md.</b> <b>8/29/58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8/29/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Ghost</b>			22d. LOCATION (City, town, or county) (State) <b>Issue, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Melvin Cannady, Father</b>					ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 15 '58</b>		24b. REGISTRAR'S SIGNATURE 	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9010

## CERTIFICATE OF DEATH

09009

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COBB ISLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Cobb Island</b>	
c. LENGTH OF STAY IN 1b <b>4 Years</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>Nathaniel</b> Last <b>DARCEY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 13, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Somerset, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nathen Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Mary Stacks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-03-0351</b>	
17. INFORMANT (Son) <b>Horace Darcey, 6112-N. 31st. Arlington, Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cardiac dilatation</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertension</b> DUE TO (c) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>10 yrs.</b> <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from the year of <b>1956</b> to <b>21 day</b> , 1958, that I last saw the deceased alive on <b>12-57</b> , and that death occurred at <b>10:10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. M. Johnson</b> M.D.		ADDRESS (Street, city or town, state) <b>La Plata, Md.</b> DATE SIGNED <b>8-21-58</b>	
PHYSICIAN'S NAME (Type) <b>F. M. JOHNSON M.D.</b>		<b>La Plata, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 24, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wayside, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard Funeral Home Inc.</b> Address <b>Arlhart Funeral Home, Inc. La Plata, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 21 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

CERTIFICATE OF DEATH

WILLIAM  
J. BROWN  
DECEASED

1900

1900

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9011**  
**CERTIFICATE OF DEATH**

09010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	c. LENGTH OF STAY IN 1b <u>52 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Russell</u> Last <u>Eastburn Sr</u>		4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-98</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman - Machine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Packer</u>	
11. BIRTHPLACE (State or foreign country) <u>Hampton, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Robert G. Eastburn</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Smithson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Edward R. Eastburn Jr.</u>		Address <u>7402 Insey St SE, Washington 28, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>14 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/11</u> , 19 <u>58</u> , to <u>8/17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/10</u> , 19 <u>58</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank G. Susan</u> M.D.		ADDRESS (Street, city or town, state) <u>5 Indian Head Ave</u> DATE SIGNED <u>8/17/58</u>	
PHYSICIAN'S NAME (Type) <u>Frank A Susan M.D.</u>		<u>Indian Head. MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>		ADDRESS <u>1661 Goldthorpe Rd SE</u> <u>Washington D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kious</u>	



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INSTRUCTIONS

**1** **BE EXECUTED WITHIN 24 HOURS AFTER DEATH.**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

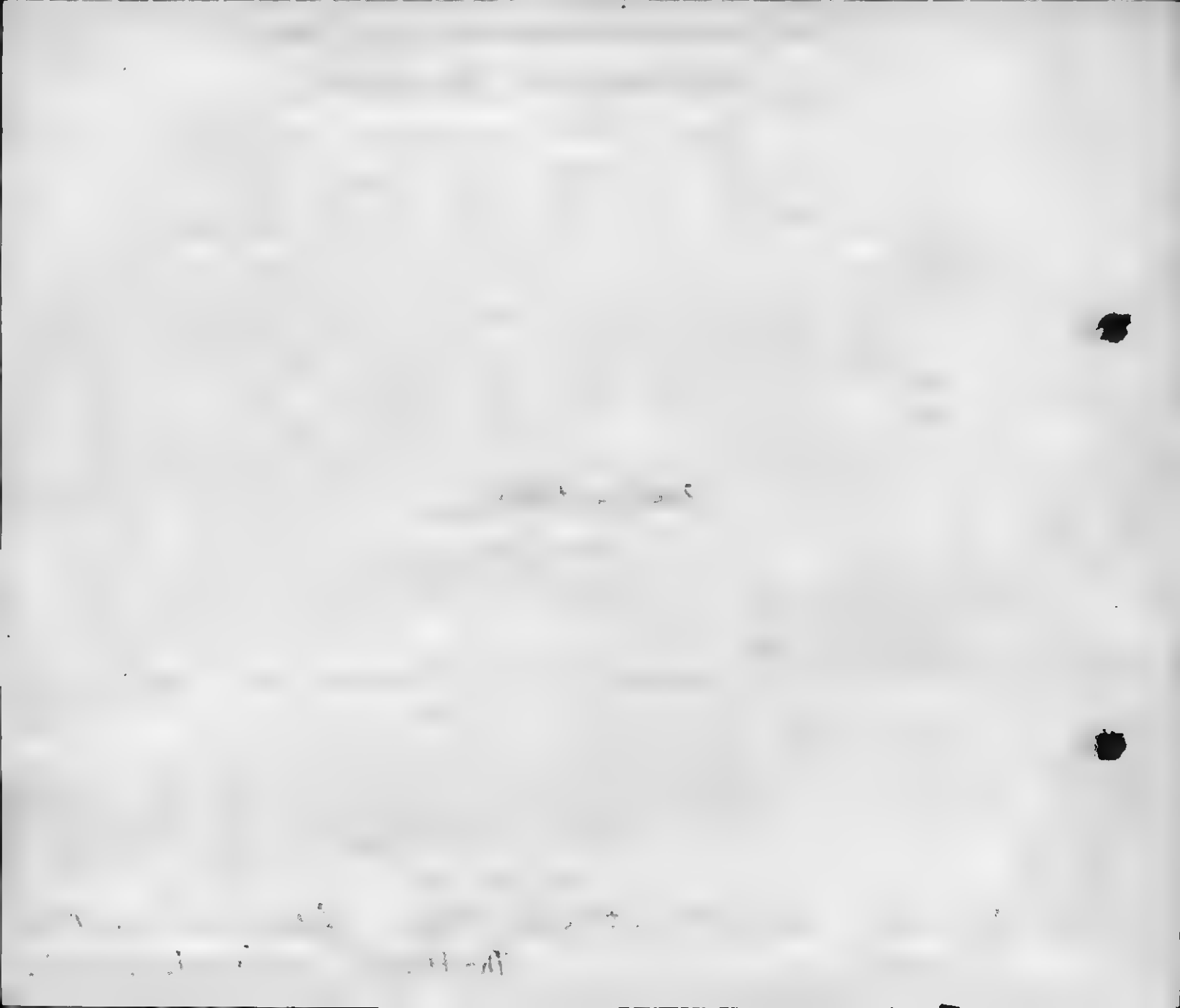
09011

9012

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		LENGTH OF STAY (in this place) <u>83 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) <u>Henry</u> (Middle) <u>Hawkins</u> (Last) <u>Hawkins</u>				<b>4. DATE OF DEATH</b> (Month) <u>August</u> (Day) <u>8</u> (Year) <u>1958</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>1874</u>	<b>9. AGE last birthday</b> <u>84</u> yrs.	<b>10. FINDER 1 YEAR</b> Months _____ Days _____		<b>11. IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Port Tobacco, Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>John Hawkins</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Letta Gray</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-12-4985</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Emelia Hawkins, Indian Head, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Acute Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Pyloro-Nephrosis</u>						<u>1 month</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) _____ (County) _____ (State) _____			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____ M. _____		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>July 3</u>, 19<u>58</u>, to <u>Aug 8</u>, 19<u>58</u>, that I last saw the deceased alive on <u>8/8</u>, 19<u>58</u>, and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Frank G. Pusan</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Indian Head, Md</u>		<b>DATE SIGNED</b> <u>8-8-58</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>8/12/58</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St Charles</u>		<b>LOCATION</b> (City, town, or county) _____ (State) _____	
<b>24. REC'D BY REGISTRAR</b> <u>AUG 13 '58</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Carl S. Kneak</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Hunt Funeral Home, Waldorf, Md.</u>			



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 (OM)

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

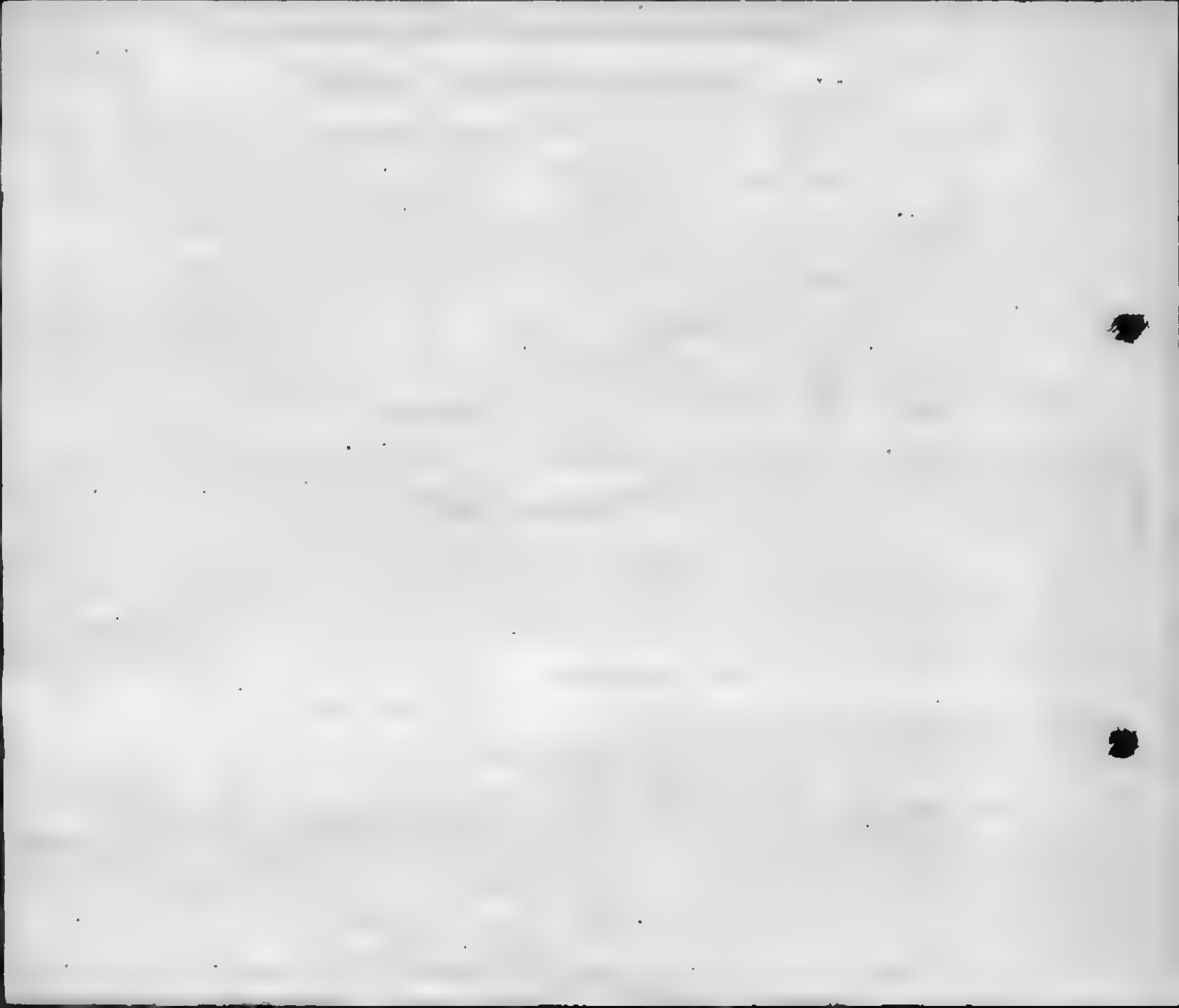
09012

9013

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <u>Indian Head Md</u>		LENGTH OF STAY (in this place) <u>41-Yrs</u>		CITY (If outside corporate limits, write RURAL end give nearest town) TOWN <u>Indian Head Md</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) /			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Catherine Rebecca Jenkins</u>				<b>4. DATE OF DEATH</b> (Month) <u>8</u> (Day) <u>24</u> (Year) <u>58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W-US</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>2-18-1897</u>	
9. AGE last birthday <u>61</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Prince George County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George R. Coomes</u>				14. MOTHER'S MAIDEN NAME <u>Catherine A. Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Thomas R. Jenkins-(Husband)</u>		Indian Head Md.	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Circulatory Collapse</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-Hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Malignant Metastasis</u>						<u>8-Mths</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Adeno-Carcinoma-<del>unknown</del> Ovarian</u>						<u>1-Yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Marked Ascites</u>						<u>5-Mths</u>	
19a. DATE OF OPERATION <u>7-11-57</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cystic Ovary-Dr Vincent Hungerford, Providence Hospital, Washington D.C.</u>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-24-58</u> , 19 <u>58</u> , to <u>8-24-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-24-58</u> , 19 <u>58</u> , and that death occurred at <u>8:30AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas R. Jenkins</u> M.D.				ADDRESS (Street, city, town, state) <u>Indian Head Md</u>		DATE SIGNED <u>8-25-58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>8/25/1958</u>		NAME OF CEMETERY OR CREMATORY <u>St. Charles Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glymont, Charles, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>SEP 2 1958</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc.</u>		ADDRESS <u>ARCHART FUNERAL HOME, INC. LA PLATA, MD.</u>	





## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>CHARLES</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LA PLATA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LA PLATA</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>JONES</i>		4. DATE OF DEATH Month Day Year <i>AUG 30 1958</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG 30 1958</i>
9. AGE (In years last birthday) yrs. <i>3</i>		10. IF UNDER 1 YEAR Months Days Hours Min <i>3 30</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wm. W BROWN</i>		14. MOTHER'S MAIDEN NAME <i>HELEN JONES</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>—</i>	
17. INFORMANT <i>Helen Jones</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO (b) <i>—</i> DUE TO (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pneumonia</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug 30, 1958</i> to <i>Aug 30, 1958</i> , that I last saw the deceased alive on <i>Aug 30, 1958</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. M. Johnson M.D.</i>		DATE SIGNED <i>Aug 30, 58</i>	
PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/1/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>	22d. LOCATION (City, town, or county) (State) <i>La Plata, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wickert</i>		24a. REC'D BY REGISTRAR <i>SEP 9 '58</i>	
ADDRESS <i>La Plata, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9015

## CERTIFICATE OF DEATH

09014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicans Memorial Hospital</b>				/d STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MARGARET S. JOHNS KEY</b> First Middle Last				4. DATE OF DEATH <b>August 3, 1958</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 8, 1901</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>La Plata, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Columbas Norris</b>				14. MOTHER'S MAIDEN NAME <b>Mary Butler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>216-22-4919</b>		17. INFORMANT <b>Mr. Hobart Key (Husband)</b> , <b>La Plata, Maryland</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephrotic Syndrome</b> DUE TO <b>Atrophy of Liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1-1-58</b> (c) <b>1956</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1956</b> to <b>8-3-58</b> , that I last saw the deceased alive on <b>8-2-58</b> , and that death occurred at <b>6</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>LA PLATA MD.</b> DATE SIGNED <b>8-3-58</b> ACTUAL SIGNATURE <b>E. J. Edelen</b> M.D. PHYSICIAN'S NAME (Type) <b>E. J. EDELEN M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/6/ 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Newtown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Newtown, Charles County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archant Funeral Home, Inc., La Plata, Maryland</b>				24a. REC'D BY REGISTRAR <b>AUG 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09015

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

9016

Items 9, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cobb Island</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cobb Island</u> d. STREET ADDRESS e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>J. REIDA</u> First <u>Mc</u> Middle <u>GUIGAN</u> Last <u>8</u> 4. DATE OF DEATH <u>8</u> Month <u>6</u> Day <u>1958</u> Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 9, 1881</u> 9. AGE (In years last birthday) <u>76.5</u> 10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>A. W.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>DC</u> 11. BIRTHPLACE (State or foreign country) <u>DC</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Julius Slader</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>111-11-1111</u> 17. INFORMANT <u>Elyse S. McQuigon</u> Address <u>2219 11th St</u>		18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vas. Accident</u> DUE TO (b) <u>Prob hypertension</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. EDELEN</u> EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-6-58</u>	
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF <u>7/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town or county) (State) <u>Seaboard Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert McTaggart</u>		24a. REC'D BY REGISTRAR <u>W. J. Esch</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Esch</u>





## CERTIFICATE OF DEATH

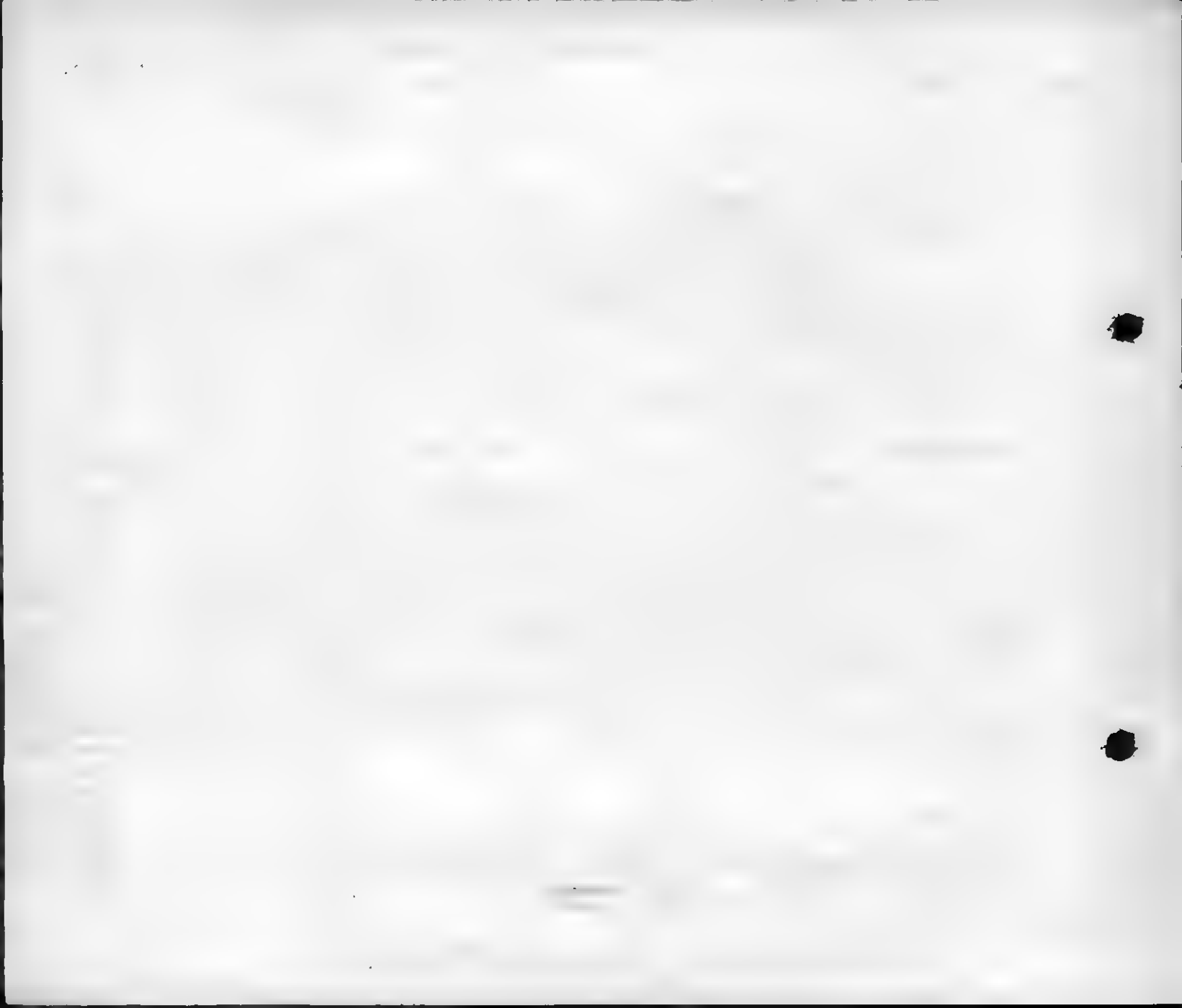
Reg. Dist. No. 09016

9017

1 PLACE OF DEATH a COUNTY <u>Charles</u>				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Carroll</u> Last <u>PICKERAL</u>				4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-58</u>	9. AGE (In years last birthday) yrs. <u>7</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward L. Pickeral</u>				14. MOTHER'S MAIDEN NAME <u>Mary Esther Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Edward L. Pickeral</u>				Address <u>White Plains Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>8-26</u> 19 <u>58</u> to <u>8-28</u> 19 <u>58</u> that I last saw the deceased alive on <u>8-27</u> 19 <u>58</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>8-28-58</u>							
ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D.							
PHYSICIAN'S NAME (Type) <u>E. J. EDELEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>		22d. LOCATION (City, town, or county) (State) <u>Pomfret, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9018

## CERTIFICATE OF DEATH

09017

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Physicians Memorial</i>		d. STREET ADDRESS <i>Indian Head</i>	
3. NAME OF DECEASED (Type or print) <i>Edward Wayne PICKLE</i>		4. DATE OF DEATH <i>AUG 26 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-26-58</i>
9. AGE (In years last birthday) <i>6</i>		10. IF UNDER 1 YEAR <i>6</i> MONTHS <i>20</i> HOURS <i>20</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <i>Robert Pickle</i>		14. MOTHER'S MAIDEN NAME <i>Doris B. Pickeral</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Robert Pickle, Indian Head Md.</i>	
17. INFORMANT <i>Robert Pickle, Indian Head Md.</i>		18. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>irreversible shock</i> 7730 DUE TO		4 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>hemorrhage from umbilical cord</i> DUE TO		4 hrs.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-26-58</i> , 19 <i>58</i> , to <i>8-26-58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8-26-58</i> , 19 <i>58</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Johnson</i> M.D.		DATE SIGNED <i>8-26-58</i>	
PHYSICIAN'S NAME (Type) <i>F.M. JOHNSON M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 27, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Josephs</i>		22d. LOCATION (City, town, or county) (State) <i>Compt. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR <i>SEP 2 '58</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6193 XV 5



9019

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Alton La Plata</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicans Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Arthur</b> Last <b>PILKERTON</b>		4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1958</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 29, 1884</b>
9 AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming self Emp.</b>	
11 BIRTHPLACE (State or foreign country) <b>Charles County</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Columbus Pilkerton</b>		14. MOTHER'S MAIDEN NAME <b>Mamie E. Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Leon Pilkerton (Son)</b>		Address <b>Bel Alton, Maryland</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Cardiac Failure</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Atherosclerotic Coronary Heart Disease</b> DUE TO (c) <b>Acute Perforation Duodenal Ulcer &amp; Peritonitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>2 YRS</b> <b>6 DAYS</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUG. 15</b> , 1958, to <b>AUG. 21</b> , 1958, that I last saw the deceased alive on <b>AUG. 21</b> , 1958, and that death occurred at <b>5:20 A.M.</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>J. Parran Jarboe</b>		ADDRESS (Street, city or town, state) <b>La Plata, Md.</b> DATE SIGNED <b>8-21-58</b>	
PHYSICIAN'S NAME (Type) <b>J. PARRAN JARBOE, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 23, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Chapel Point, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, Inc.</b>		24a REC'D BY REGISTRAR <b>Aug 27 '58</b>	
24b REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All death certificates are completely filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





9020

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Physician Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Nanjemoy</u>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>W.</u> Last <u>SANDERS</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 Sept 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Berry W. Walter Miltstead</u>		14. MOTHER'S MARDEN NAME <u>Baxter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Worthy W. Sanders, Doncaster, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Cerebral vascular accident.</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>4 days</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>48</u> , to <u>8 Aug</u> 19 <u>58</u> , that I last saw the deceased alive on <u>8 August</u> 19 <u>58</u> , and that death occurred at <u>9:43 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur O. Woody</u> M.D. <u>Sanwood Clinic</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8 Aug 58</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY, MD.</u>		<u>La Plata, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chicamuxen M.E.</u>	22d. LOCATION (City, town, or county) (State) <u>Chicamuxen, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Prange</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Although this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9021

## CERTIFICATE OF DEATH

69020

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>5 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>Cooper</b> Middle <b>SCHAFER</b> Last		4. DATE OF DEATH <b>AUGUST 28</b> 19 <b>58</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1894</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Salesman</b>	
11. BIRTHPLACE (State or foreign country) <b>Chicago, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Schafer</b>		14. MOTHER'S MAIDEN NAME <b>Ann Howe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. I</b>		16. SOCIAL SECURITY NO <b>187-22-3093</b>	
17. INFORMANT <b>Mrs. Virginia Schafer (Wife)</b>		Address <b>La Plata, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10 yrs</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 1957</b> to <b>Aug 28, 1958</b> , that I last saw the deceased alive on <b>23 Aug 1958</b> , and that death occurred at <b>1:20 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>F. M. JOHNSON</b> M.D.		ADDRESS (Street, city or town, state) <b>La Plata, Md.</b> DATE SIGNED <b>8-28-58</b>	
PHYSICIAN'S NAME (Type) <b>F. M. JOHNSON, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL-Removal</b>	22b. DATE THEREOF <b>8/30/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Alagany Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pittsburgh, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>AREHART FUNERAL HOME, INC. LA PLATA, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>SEP 2 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneak</b>

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and is to be used for the funeral, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9022

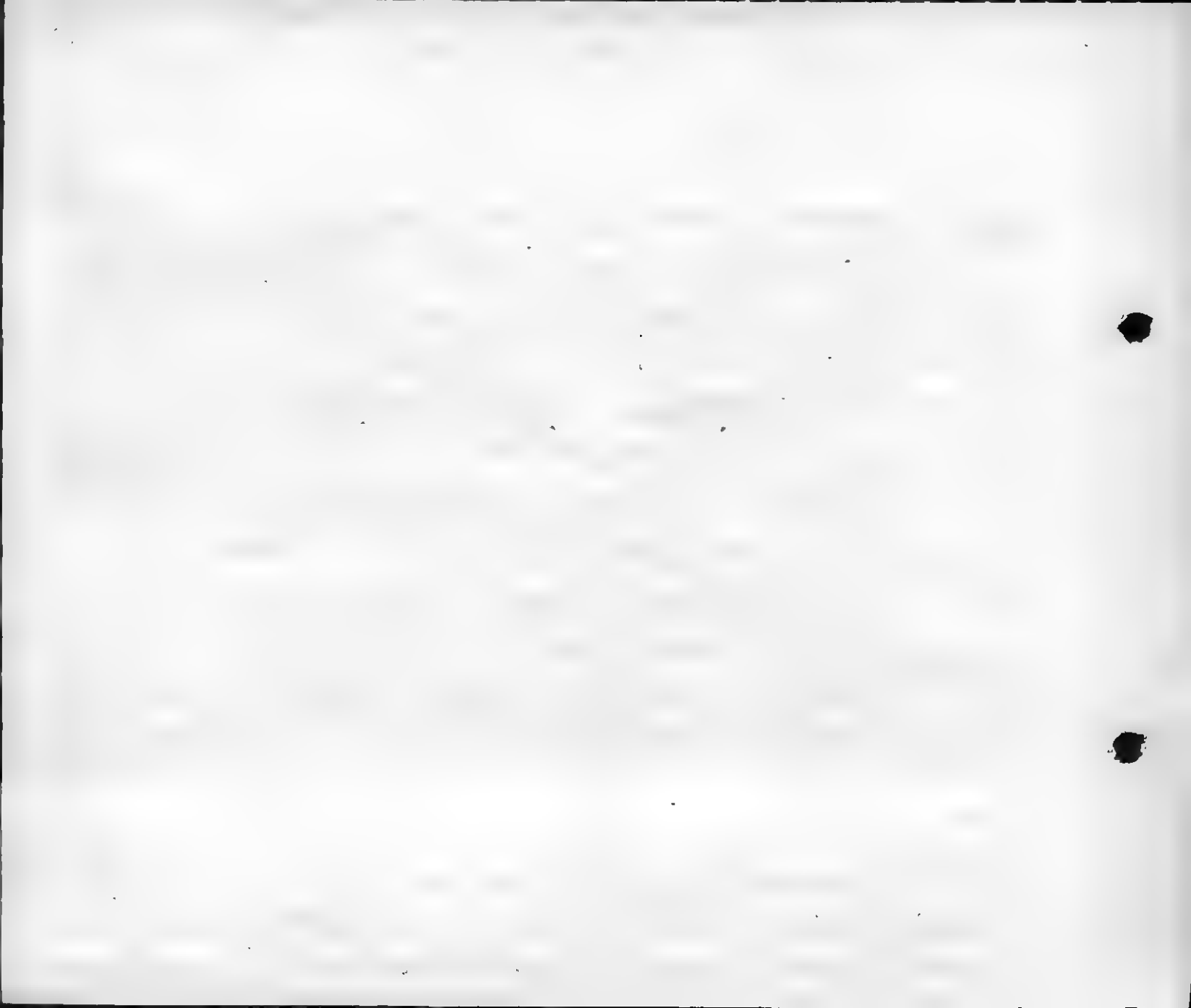
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benedict</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benedict</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA MAY TOYE</u>		4. DATE OF DEATH Month Day Year <u>Aug 25 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 15 1865</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Agustus Lavoie</u>		14. MOTHER'S MAIDEN NAME <u>Susie Tyler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>EVERETT TOYE</u>		Address <u>Benedict MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 YR.</u> <u>3 YR.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1957</u> , to <u>Aug 24 1958</u> , that I last saw the deceased alive on <u>Aug 24 1958</u> , and that death occurred at <u>12:00 PM EST</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. PARRAN JARBOD</u>		DATE SIGNED <u>8-25-58</u>	
PHYSICIAN'S NAME (Type) <u>J. PARRAN JARBOD</u>		ADDRESS (Street, city or town, state) <u>La Plata, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 28 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Peter's</u>	22d. LOCATION (City, town, or county) (State) <u>Waldorf MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>		24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>	
ADDRESS <u>Waldorf MD</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Fries</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09022

9023

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>		c. LENGTH OF STAY IN 1b <b>x Waldorf.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL HOSP.</b>		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W.</b> Last <b>TROTTER</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>9</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 APRIL 1958</b>
9. AGE (In years last birthday) yrs. <b>4</b> Months <b>6</b> Days <b>8</b> Hours <b>Min.</b>		10. IF UNDER 1 YEAR <b>4</b> Months <b>6</b> Days <b>8</b> Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard E Trotter Jr</b>		14. MOTHER'S MAIDEN NAME <b>Mary M. Simpson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Howard E. Trotter Jr, Waldorf, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO <b>7545</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure</b> DUE TO <b>3 wks.</b> (c) <b>Congenital defect of heart</b> <b>4 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 April</b> , 19 <b>58</b> , to <b>9 August</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9 August</b> , 19 <b>58</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur O. Woody</b> M.D.		ADDRESS (Street, city or town, state) <b>LAPLATA, MARYLAND</b>	
DATE SIGNED <b>10 August</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/12/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Peters</b>		22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		ADDRESS <b>2066 323 XV 4</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WALTON ROAD

1 HAD. COTTAGE

John W

3003

CERTIFICATE OF DEATH

WATKINS & SONS, LTD. 10

Howard E Trotter Jr. May 11. 2. m. 1900  
Howard E. Trotter Jr. May 11. 2. m. 1900

Howard E. Trotter Jr. May 11. 2. m. 1900  
Howard E. Trotter Jr. May 11. 2. m. 1900



## CERTIFICATE OF DEATH

Reg. Dist. No.

09023

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAMAR</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>		d. STREET ADDRESS <b>Rural - Faulkner.</b>	
3. NAME OF DECEASED (Type or print) <b>Lola</b> First <b>Whalen</b> Middle Last		4. DATE OF DEATH <b>August 23</b> Month Day Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>?</b> 1900 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wesley Brown</b>		14. MOTHER'S MAIDEN NAME <b>Josephine ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Randolph Whalen, Newburg, Md.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Collapse</b> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastasis of Carcinoma of bladder</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>5 years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>18 Aug., 1958</b> , to <b>23 Aug., 1958</b> , that I last saw the deceased alive on <b>23 Aug., 1958</b> , and that death occurred at <b>5:36 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur O. Woody</b> M.D.		ADDRESS (Street, city or town, state) <b>La Plata, Md.</b> DATE SIGNED <b>23 Aug. 58</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/26/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>	22d. LOCATION (City, town, or county) (State) <b>Chaptico, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>SEP 2 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: John J. Smith

2. Sex: Male

3. Age: 65

4. Date of birth: Jan 15, 1885

5. Place of birth: St. Louis, Mo.

6. Date of death: Dec 10, 1950

7. Place of death: Home

8. Cause of death: Heart failure

9. Immediate cause: Myocardial infarction

10. Underlying cause: Coronary atherosclerosis

11. Contributing causes: None

12. Signature of physician: [Signature]

13. Signature of registrar: [Signature]

14. Date of filing: Dec 15, 1950

15. File number: 100-123456